DOCUMENT RESUME

ED 237 897 CG 017 152

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TITLE Modeling Hospital Discharge and Placement Decision Making: Whither the Elderly.
SPONS AGENCY Health Care Financing Administration (DHEW), Washington, D.C.
PUB DATE Apr 83
GRANT 11-P-96553/9-03
NOTE 41p.; Paper presented at the Annual Meeting of the Western Gerontological Society (29th, Albuquerque, NM, April 16-20, 1983).
PUB TYPE Reports - General (140) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Agency Role; Cooperative Planning; *Decision Making; Health Personnel; Long Range Planning; *Medical Services; Models; *Older Adults; Physician Patient Relationship; *Placement; Social Support Groups; Social Workers; Systems Analysis
IDENTIFIERS *Long Term Care

ABSTRACT

This paper examines the hospital discharge decision making process for elderly patients, based on observations of the operations of a long term care agency, the California Multipurpose Senior Services Project. The analysis is divided into four components: actors, factors, processes, and strategy critique. The first section discusses the major actors in the discharge and placement decision making process, i.e., the treaters (physicians, nurses, social workers, and discharge planners), the timekeepers (utilization reviewers and medical reviewers), and the supporters (patient, family and friends, and outside agencies). Each actor's role and impact on the decision making process is discussed. Next, three factors, treatment purpose, treatment cost, and patient resource structure, which influence both length of placement and decision making behavior, are analyzed. The decision making process is examined in terms of the relationship between these three factors and the behavior of the actors. Based on this interaction, a discharge and placement model is offered and illustrated in a series of charts. Implications of the decision making process for community-based long term care agencies are discussed and suggestions are offered to facilitate identification of hospitalized clients who will benefit from placement in a long term care facility. A critique of the model, with an eye toward the realities of the social world and the medical actors, completes the paper. (BL)

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Modeling Hospital Discharge And Placement Decision Making: Whither the Elderly

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CG 017152

Paper presented at the 29th Annual Meeting of the Western Gerontological Society, Albuquerque, New Mexico, April 16-20, 1983.

ACKNOWLEDGEMENTS

Research for this paper was supported by Health Care Financing Administration Grant No. 11-P-96553/9-03. The able assistance of Diann Haines in preparation of the manuscript and of Arthur Miller in preparation of the figures are greatly appreciated. The authors would also like to acknowledge the aivice and comments on earlier drafts of this paper by Professor Leonard S. Miller and Robert Pruger from the School of Social Welfare, University of California, Berkeley; from Paul Newacheck, Institute for Health Policy Studies, University of California, San Francisco; from Martin and Renata Chase; and, from Merwyn Williams, Director, Multi-purpose Senior services Project. The authors are solely responsible for the contents of this paper.

When Do You Go Home: Hospital Discharge and Placement Decisions for the Elderly and Implications for Community Based Long-Term Care Agencies

Hospital discharge and placement decisions in the United States are billion dollar decisions, [1] yet, knowledge about the processes leading up to such decisions is fragmentary [2,3] or prescriptive [4,5] about how the process should work, e.g., discharge planning, not about the problem of who makes the decisions, under what conditions, how, and why.

This study was undertaken to gain a better understanding of discharge and placement decisions to suggest ways that community-based long-term care agencies, serving the elderly, may intervene to shorten lengths of stay, ensure appropriate placements, and affect the consumption of health care dollars. The study is based on the authors' observations about the decision making process and the operations of one long-term care agency, the California Multi-purpose Senior Services Project. [6]

Elders' hospitalizations represent a special situation since age acts as an independent variable. Age affects the probability of admission, the hospital experience itself, and the average length of stay (ALOS).[7] As a resident physician in a large teaching hospital told us, "You can always find something wrong with an old person and the longer you have them in the hospital, the more you find wrong." In addition, the elderly suffer more untoward reactions as a result of hospitalization than do other age groups. [8]

This analysis of discharge and placement decision-making is divided into four components. First, we identify the social actors involved, highlighting the primacy of the physician; second, the factors affecting the length of stay and placement are described through the use of three dimensional figures; third, we construct a mode of intervention in the discharge and placement decision making process; and, finally, we offer a self-critique of our strategy given the realities of the social world.

Dynamics of the Discharge and Placement Decision Making Process: Actors, Factors and Processes.

Actors

Our observations lead us to believe there are three types of actors in the discharge and placement decision making process. They are "treaters", "timekeepers" and "supporters". Figure 1 depicts the constellation of these groups and what follows are descriptions of their roles.

Treaters

Physicians

Discharge and placement decisions, contrary to democratic group process models, are always made by physicians with varying amounts of input from others. These decisions are almost always made during rounds of one sort or another when physicians spend a few minutes per patient. Physicians as primary treaters are not unlike mobile computers

Figure 1

PRINCIPAL ACTORS IN THE HOSPITAL DISCHARGE AND PLACEMENT DECISION MAKING PROCESS

SUPPORTERS

- Patient
- Family and Friends
- Outside Agencies

TIMEKEEPERS

- Utilization Reviewers
- Medi-Cal Reviewers

TREATERS

- Physicians
- Nurses
- Social Workers
- Discharge Planners

in relation to other actors in the discharge and placement decision making process. Potential information regarding a patient's physical, psychological and social statuses is input by professional staff, the patient, and the patient's family, all acting as feeders and decisions are physician outputs.

Although the decision per se is made by the physician, the timing of the execution of that decision is negotiable. These negotiations are between the social actors involved in the discharge and placement decisions who have different power bases and professional orientations, different timing realities, different definitions of what constitutes a positive outcome and the best means to that end. The actual interactions that make up these negotiations are described as we discuss the roles of the different actors.

Physicians' goals in discharge and placement decisions are to provide the best patient care which, more often than not, means to avoid the worst possible outcome. However, negative outcomes are conceptualized from the physician's point of view. Anything that impinges on the physician's professional experience or flow of production begins to consume the most valuable of assets - time. The old adage that time is money is particularly true for physicians since their workloads tend to be large. For example, one study indicated that office based physicians average between 142 and 229 office visits a week.[9] Any discharge or placement that is perceived as having the potential of costing time is preceived as being expensive - for the physician.

A physician's tendency to value time, further reinforced by fee-for-service reimbursements, has the effect of not investing non-billable time, or time not related to direct patient care, in meetings with social workers, discharge planners or other activities which bring no clinical experience or financial return. In teaching hospitals, with salaried interns and residents, our observations lead us to believe that the orientation toward time is to maximize the acquisition of clinical medical knowledge and experiences tempered by workloads.

Another physician value relevant to understanding the decision process concerns autonomy and the degree to which physicians share their traditional power with other staff. That is, physicians who view themselves as autonomous "Captains of the Ship" (and according to hospital staff interviewed, most see themselves this way) and perceive hospital social workers and discharge planners as instruments to carry out their orders tend not to involve other staff in discharge decisions until the last moment, if at all. "Ship Captains" do not choose to involve staff since they see themselves entirely responsible for the patient and some staff attribute this attitude to a perceived potential loss of power.

This last minute informing of staff of the discharge decision, almost always made solely by the physician while on rounds and based on just medical criteria, may have several negative effects on the discharge date and placement.[10] If social workers and discharge planners can buy more time, by either appealing to the physician or to utilization

review staff or Medi-Cal (Medicaid in California) reviewers or application of some stalling tactics, the discharge date will be delayed as they align the appropriate community resources for after care. If they are successful, the patient has a higher hospital bill than if the physician had a participatory attitude toward power and had taken the time to ask them early on, "What can we do?", thereby facilitating a timely discharge. Given our observations that social workers and discharge planners always opt for a patient's return to home whenever humanly possible, the very fact that a social service worker has participated in a discharge and placement decision can increase the probabilities of returning home.

In regard to placement decisions - discharge to home or to a skilled nursing facility (SNF) - the predominant physician strategy is to avoid the worst possible outcome and minimize time consumed. For example, if the physician is faced with the decision to place a patient in a SNF or discharge to home, the physican has to consider what will happen if the patient turns for the worst or recovers without a problem and, for a fee-for-service physician, what these outcomes will mean in terms of time, e.g., calls at night if a home placement turns for the worse. For salaried physicians, outcomes are determined by the placement path of least resistance.

For example, for salaried interns and residents, in large teaching hospitals, the strategy is to "treat and turf". That is, physicians-in-training prefer to maximize the variety of clinical experiences and

not invest time a necessary concomitant of after care plans. As one hospital staff person told us, "Patients are discharged to the curb."

Further reinforcing this strategy which minimizes time spent per patient is stereotyped thinking that tends to institutionalize aged patients almost automatically.[11] For example, physicians told us that they had developed several heuristics, or rules of thumb, when treating elderly patients in the hospital. One physician matter-of-factly told us that if an elderly patient is in the hospital for a week, he always places the patient in a SNF since, "They all go senile after being in for a week". Another told us that if the elderly patient comes from a SNF, he always discharges back to the SNF.

The exception to the SNF placement bias, for both salaried and fee-for-service physicians, occurs if there is aggressive action on the part of the patient or significant others opposed to the decision. Opposition here is again time consuming so the physician takes the placement path of least resistance.

The physician's professional orientation will also affect the discharge and placement decisions. At the risk of oversimplifying the existent literature about the medical profession, we divide the orientation of the physician into "scientists" and "healers". The main difference is that the "scientist" is disease, organ, or knowledge focused while the "healer" is focused on the total person. An example of how these different orientations may affect discharge is the decision

to order a test that is marginal and expensive in a particular case and is painful to the patient, e.g. a bone marrow test. In these marginal situations, the scientist will tend to order the test, thereby extending the length of stay, whereas the healer will not.

Nurses

For nurses as secondary treaters, time takes on another dimension. Time is perceived in relation to numbers and kinds of task to be accomplished vis-a-vis the patient. Nurses, as part of the professional line of authority within hospitals, as opposed to the administrative line, [12] participate to the degree permitted by the physician, but they are major sources of information. Overall, nurses are the sympathetic voice and principle interpreter of the patient. The degree to which they sare their information with discharge planners and social workers, who the nurses sometimes perceive as part of the administration structure and therefore by definition as non-professionals, is more a function of personality and the total working ambiance of the hospital. It should be noted, however, that salaried nursing staff do not have incentives to shorten lengths of stay, since, in the long run, shorter lengths of stay will mean heavier workloads given hospitals' propensity to fill empty beds [13,14] and the relative intensity of services supplied during the first few days of admission. [15]

Social Workers and Discharge Planners

For social workers and discharge planners as tertiary treaters, time takes on the reality of the social world compounded by the tendency

to be the last to know among the principal actors about decisions.[16] For social workers as patient advocates and discharge planners seeking a good placement the task is to negotiate interfaces among and between patients recovery time:("They kept him on three days of bed rest to get him stable and now he cannot walk."); physician's turn around time: ("The docs are thinking about doing a G.I. work-up but the debate was tabled at rounds this morning."); insurance and Medi-Cal reviewer time: ("The patient is an illegal alien with no insurance and the county SNF won't take him."); family and friends' time: ("His only son has not returned any of my calls for a week and his nephew is a chronic alcoholic.") and the business hours and lead times of community agencies and facilities: ("Today is Friday of a three-day weekend and the SNF wants to make sure his skin is clear and a $1,700 check clears the bank on Tuesday before they admit him - maybe.")

In light of these structural and interactional constraints, social workers and discharge planners are more often than not reduced to the task of selecting a SNF rather than exploring alternatives, or, arranging for transportation to a social vacuum, that is, discharging without being able to take the social context into consideration.

Timekeepers

Utilization Review and Medi-Cal reviewers

For utilization review staff (as part of the Professional Standard Review Organization, PSRO) and Medi-Cal reviewers, individuals charged with the business of timekeeping in hospitals, time is also a valuable resource. Reviewers are essentially guardians of the public purse, and

again, as time is money, the tools of their trade are the clock and the calendar. Armed with the mandate of legislated regulations in one hand and average length of stay (ALOS) reference texts in the other,[17,18,19] the utilization review examiner and Medi-Cal reviewer act as prompters in the discharge decision making process. That is, they stand at stage left in the drama of hospitalization and remind actors that the line is to get patients out of the hospital.

Our observations have been that many reviewers are cue givers in the literal sense in that they inform or remind physicians of the words or phrases (documentation) that must be written in patient charts in order to legitimize an appropriate longer than average length of stay. Regarding documentation, a PSRO reviewer in a rural county hospital remarked that "Doctors are cooperative here, but dense, forgetful and lazy about documentation. They also resent feds and females telling them what to do."

A utilization reviewer, an employee of the hospital and "insider", is usually a nurse and she may have an office in the hospital or circulate among several. Her reviewer role is not well received by others in the decision making process and her relatively low status often places her in an office cubbyhole somewhere in the basement of the hospital. We observed several offices located in remodeled janitor's closets, next to freight elevators, in tunnels connecting other buildings and in temporary trailers outside the main hospital. We also noted that hospital administration frequently grouped utilization reviewers, discharge planners

and social workers in these same cubbyhole offices. Usually women and nurses, we soon nicknamed such groups as the Three Graces.

The utilization reviewer's "outside" counterpart is the Medi-Cal reviewer whose role and status are comparatively similar. Like the utilization reviewer, the Medi-Cal reviewer is usually a nurse and makes the rounds to assigned hospitals on a daily basis. She checks patients' charts for length of stay and acute condition compliance, and either allows more time or decertifies the patient. The Medi-Cal reviewer, like the utilization reviewer, does her rounds with a face-to-chart check as opposed to a face-to-face check on patients. Given the difficulty and guilt implications associated with a close decertification judgement call, it is probably better for the emotional health of reviewers not to see the human costs of some regulations being strictly enforced.

Strict enforcement and the intensity of enforcement of Medi-Cal regulations varies by community and hospital type. Our findings indicate that a hospital's financial status is the best predictor of vulnerability to reviewers sanctions. Where lost revenue has been keenly felt in a budget, a reviewer's presence can have a significant impact on discharge decisions.

In some communities, strict interpretation and intensity of enforcement of Medi-Cal regulations have created adversary relationships in an atmosphere of hostility. Hospital staff's comments directed toward

Medi-Cal reviewers range from: "She's just doing her job" to "I can take care of them with one line in the chart" to "I'd like to slap a catheter on her!" Social workers and discharge planners argue that a patient's social context is never taken into consideration by reviewers and the patient is rendered decertified as soon as he/she is no longer acute.

A kind of cat and mouse game has emerged between Medi-Cal reviewers and other discharge decision staff. Because length of certified stay is linked to the patient's being in an acute status, the cat and mouse game consists of creating an acute status to buy convalescence or placement time as per the realities of the social context. The patient is, as one social worker told us, "Dead until discharged".

Gameboards for these creative notations are medical records or charts. This is significant as the chart is a legal document and the formal written communication link between the actors and it is the chief source of information for reviewers. Fabian tactics in the craft of social work must necessarily involve some negotiations with physicians for written orders and one physician summed up the practice as a "necessary evil". However, orders may not always be necessary. One director of social services in a mammoth county hospital boasted that, "I have sharpie workers here who can lose patients for days - a week - in this place." An utilization reviewer in a rural private hospital with the dual role of discharge planner explained that as a hospital employee her task is to follow the guidelines of the regulations, protect the hospital - "fix

up the chart" - and do discharge planning - all at the same time. When asked how she as discharge planner buys time for herself as reviewer she responded, "More Heparin-lock I.V.'s are started that way - to keep Medi-Cal off our backs."

Other tactics, as told to us by other staff in other hospitals include:

- "Ordering a psychiatric consult."
- "Ordering a neurological consult."
- "Ordering five days of physical therapy and calling it progressive ambulation."
- "Discovering a decubitis" ("Chart reddening on the buttocks and no SNF will touch them").
- "Charting an elevated temperature."
- "Charting that electrolites are down." ("If you don't encourage fluids to a confused aged patient who can't get out of bed, you can mess up the electrolites in a day and a half.")
- "Keeping a drain in a decubitis for another day or two."
- "Charting: OK, Progressing Satisfactorily, not ready for discharge." ("Better still, charting: just 'OK' and the first initial of your last name.")
- "Charting bacteria traces in stool or urine."

Medi-Cal reviewers are aware of acuteness ploys, of course, and are obliged to force the issue. When this happens, it is the patient who gets

caught in the middle. For example, an elderly bag lady living in a church pew was admitted to an urban city and county hospital for swelling of the lower extremities. Following bed rest and an improved diet, she returned to stable condition. The Medi-Cal reviewer then decertified her as no longer acute while the social worker was still searching for a home. The bag lady was discharged and admitted a few days later with severe swelling of the lower extremities, all according to the rules.

Supporters

Patient

The patient is his/her own most critical supporter. Sources of patient self-support are: willingness to accept or relinquish the sick role; financial status and insurance coverage; and physical functioning ability. More independent individuals, both emotionally and financially, tend to have shorter length of stay and return home. The physical side of the patient component of the resource structure refers to an individual's functional abilities. Hospital staff have indicated to us four functioning red flags when organizing discharge and placement plans; ambulation, continence, mental status, and the presence of decubiti. This later characteristic renders an appropriate SNF placement problematic. SNF administrators are reluctant to accept patients with decutitus fearing that licensing inspectors will observe them and may levy a fine or warning attributing the decutiti to lack of care at the SNF. If any one or more of these abilities are rendered problematic,

so is discharge and placement. Similar functional disabilities rendering discharge and placement problematic have been reported elsewhere.[20]

Family and Friends

Family and friends as supporters make up what is referred to as the informal support system. This component is not simply a dichotomous variable--patient does or does not have--but, when present, family and friends' capability and willingness to assist the patient must be considered. Informal support then, is a negotiated network that changes over time and its nature can either speed up or slow down a discharge or a placement depending on the geographical and relational mesh. The only time a helping well meshed informal network can slow down a discharge is when it objects to the choice of a particular SNF, either because of its geographical location or because of ethnic considerations, e.g., staff must speak Armenian.

Outside Agencies

Traditional formal service agencies, e.g., welfare departments, are usually functioning in a bureaucratic time mode and this has potentials for a slow motion time warp from the point of view of hospital staff. Service agency personnel respond that they are always the last to know and that hospital staff never give them enough time. Even given this and a dependency on the good will of family and friends, a helping informal/formal support system will usually mean a shorter than average length of stay and a placement to home.

Summary Description of Actors

Actors involved in discharge and placement decisions, with different power bases and professional orientations, different timing realities, different professional values, different definitions of what constitutes a positive outcome and the best means to that end, constitute a strained coalition [21] operating within an institutional context. They do not behave as a "team" working toward a common goal exhibiting solidarity in their behaviors. Description of the discharge planning "team" or of the acute care "team" are generally misleading and do not permit a greater understanding and appreciation of the individual preferences, complexities, and tensions involved. One discharge planner described to us the relationship between physicians, nurses, reviewers, social workers and discharge planners as "open warfare." We found this to be true more often than what the extant clinical literature would lead us to expect.

Factors

Actors in discharge and placement decisions are constrained not only by interactions with other actors but also by structural factors that provide the framework for their behaviors. Three factors we observed to influence length of stay and placement assignment after discharge, and behavior are:

1. Treatment purpose;
2. Cost to the hospital; and,

3. Resource structure.

These factors can be conceptualized as continua ranging from low to high and Figure 2 is a depiction of these factors. As we show, if a patient can be placed on this continua we can predict whether the length of stay will be shorter or longer than average and whether the placement will be to home or to a SNF. To understand how this model works we first define the three factors.

Treatment Purpose

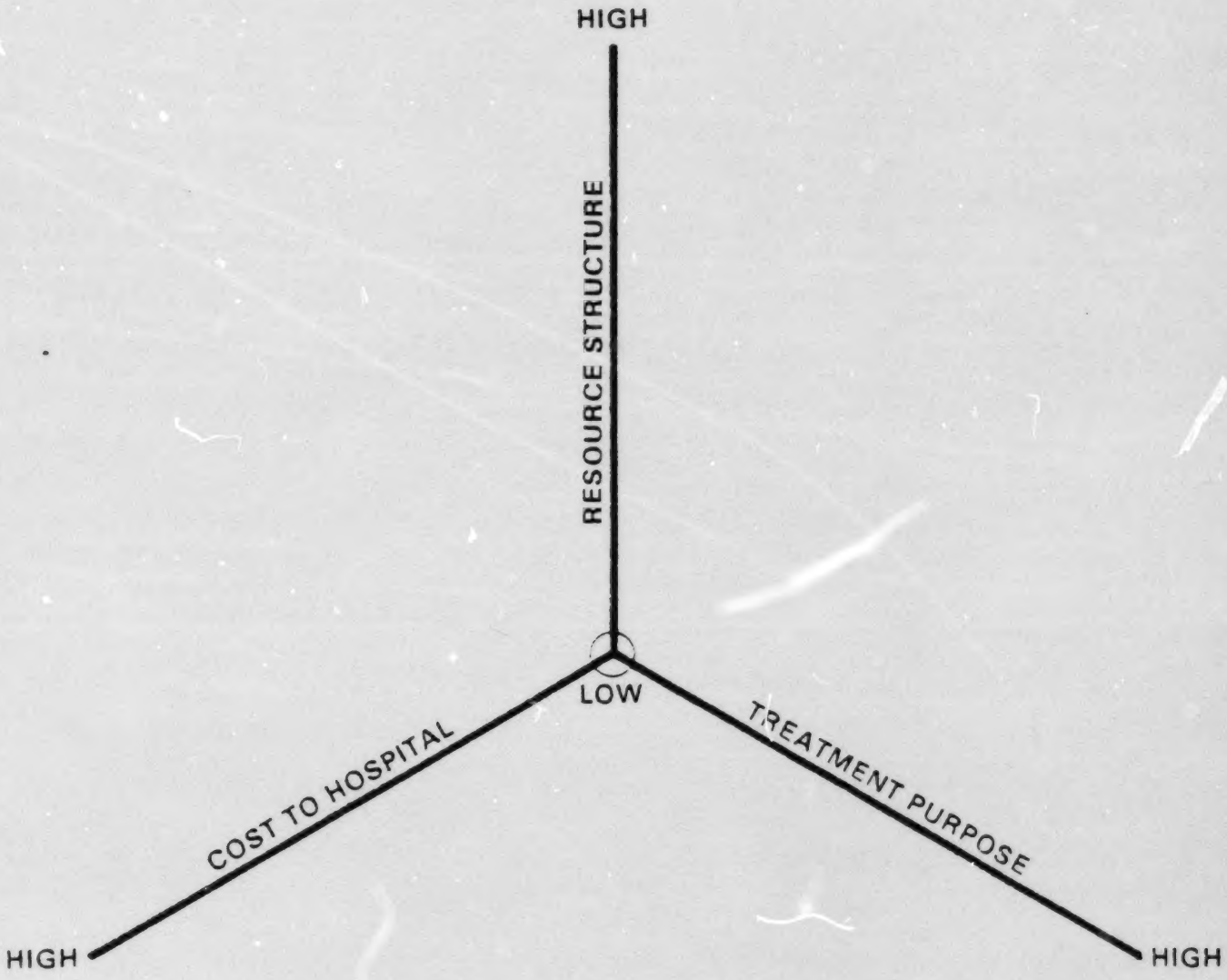
By treatment purpose we mean the intended outcome desired by the hospital admission. This outcome may be conceptualized as an end toward which all medical interventions are directed - although some medical procedures carried out during the course of hospitalization can become ends in themselves, e.g., learning purposes. Treatment purposes range from low complexity, e.g. cataract surgery, to highly complex and multiple, e.g. hip replacement, and seem to be the dominant factor which influences length of stay.

Cost to the Hospital

Cost to the hospital means costs associated with treatment purposes that hospitals have to absorb. In cases of Medicare and Medi-Cal patients, incurred costs most frequently occur when Medicare utilization review or Medi-Cal reviewers deny continued acute care coverage. The reasoning behind Medi-Cal and Medicare cost reduction strategies focuses on operationally defining medically necessary admissions and operationally defining acute medical condition. Certified length of stay in days is

Figure 2

FACTORS INFLUENCING LENGTH OF STAY AND PLACEMENT ASSIGNMENT



linked to average acute days of a particular condition. Non-acute equal denied days which equal lost revenues which equal high cost to the hospital.

Resource Structure

Components of resource structure have less influence on length of stay per se but tend to dominate placement assignment decisions. The four components of resource structure are:

1. Patient;
2. Family and friends;
3. Environment; and,
4. Hospital type.

The patients' willingness to accept or reject the sick role; financial status, and, physical functioning ability can be viewed as resources. More aggressive, articulate and questioning patients (an independent self concept) will not only have a shorter length of stay (if they want out) but also are more likely to avoid placement in a skilled nursing facility. An independent attitude appears to help keep a patient in control of the total institution world of hospital. [22] As mentioned above, more independent individuals emotionally, financially and physically, tend to have shorter length of stay and return to home.

As we pointed out, family and friends as supporters make up what is referred to as the informal support system and when present, willing, and able, will facilitate a timely discharge to home.

Environment encompasses not only physical characteristics of the

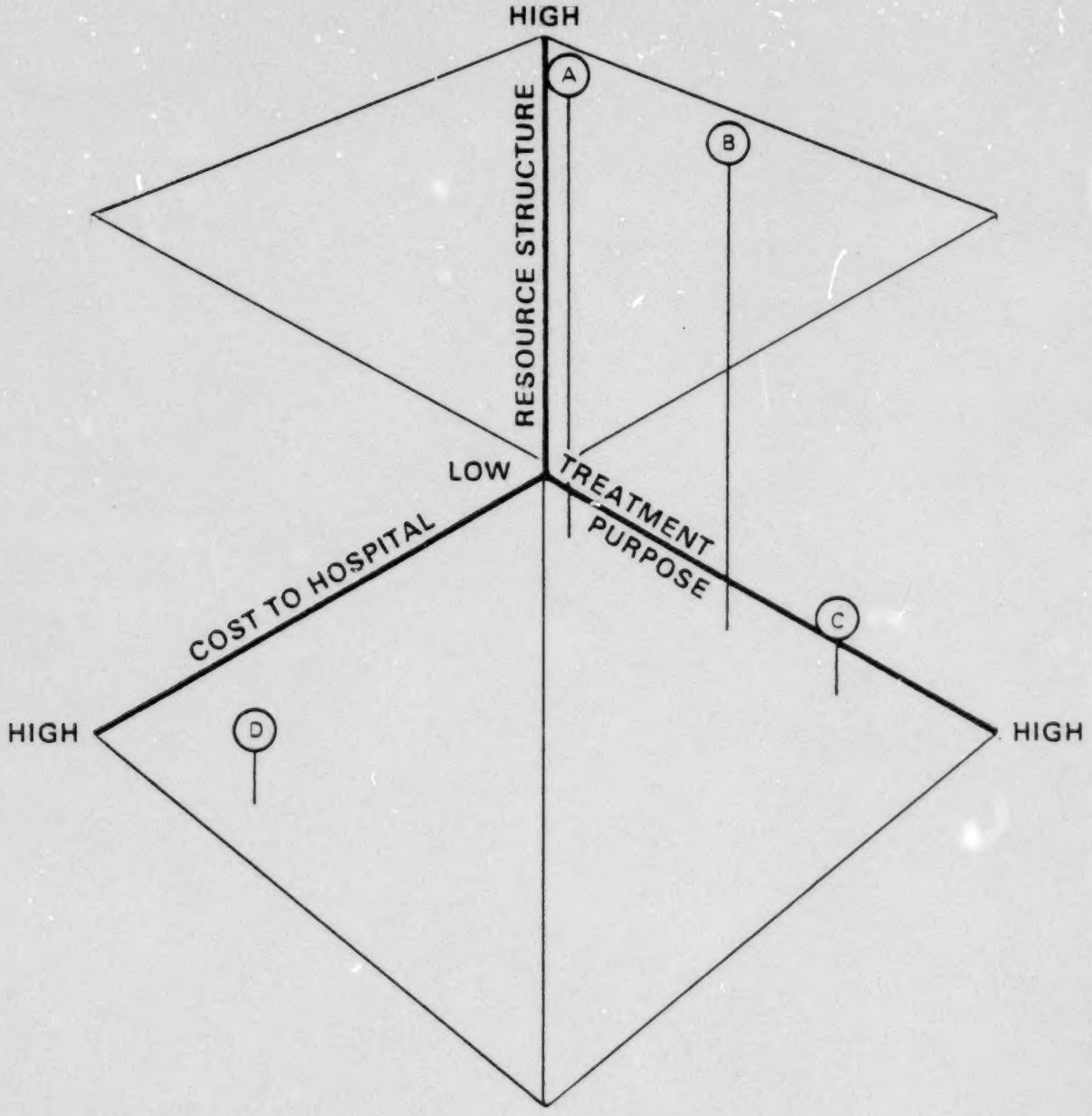
patient's residence and community, but also services available for after care. Even if a plethora of services are in supply (both for home care and skilled nursing), consideration must be given to questions of access, eligibility, reimbursement policies, perceived quality, and the patient and patient's family willingness to accept the service(s).

Hospital type and occupancy rates are frequently used characteristics in multi-variate analyses of length of stay and have shown that large non-profit hospitals, particularly large teaching hospitals, tend to have longer lengths of stay.[13,14,23,24] Another hospital characteristic which may affect discharge and placement decisions is the kind of outside services which the hospital possesses. For example, we speculate that the behavior of staff and physicians of a hospital that operates a SNF connected to the hospital by a tunnel would be different from the hospital that owns and operates a home health agency specializing in visiting nurse services at home.

According to where the patient is located on the three continua of treatment purpose, resource structure, and cost to the hospital the discharge will occur sooner or later than average and placed in a SNF or at home. For example, Figure 3 depicts four possibilities using a three dimensional illustration. Patient A represents a person with low treatment purpose, low cost to the hospital, and high resource structure. In this case, we posit that the person will have a shorter than average length of stay (ALOS). Patient B is the same situation except that the treatment purpose is more complex, resulting in a longer than ALOS.

Figure 3

PATIENTS WITHIN HOSPITAL DISCHARGE AND PLACEMENT DECISION MODEL



LEGEND:

PATIENT	TREATMENT PURPOSE	RESOURCE STRUCTURE	COST TO HOSPITAL
A	LOW	HIGH	LOW
B	MEDIUM	HIGH	LOW
C	MEDIUM-HIGH	LOW	LOW
D	LOW-MEDIUM	LOW	HIGH

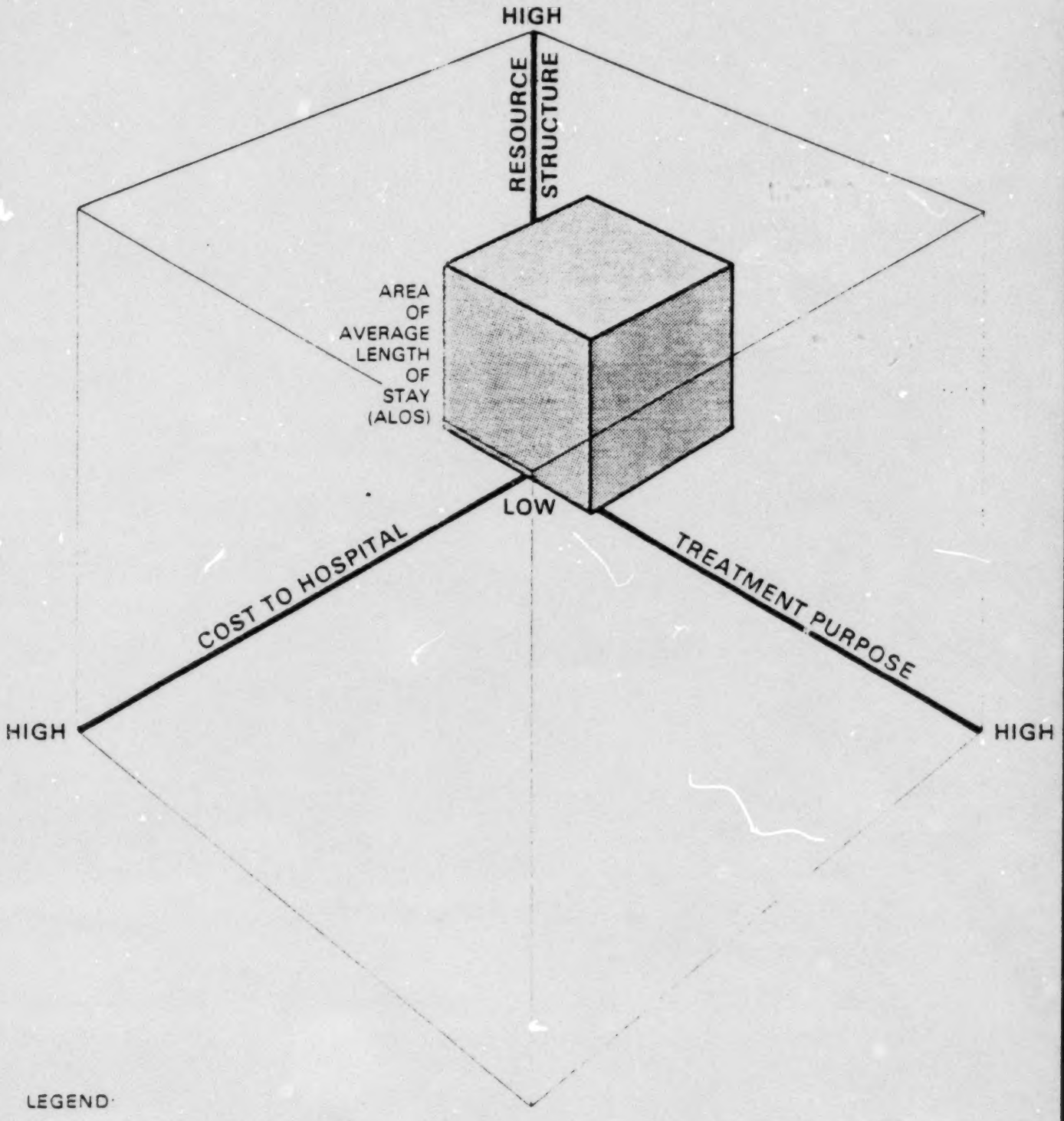
Because this person's resource structure is relatively high, we predict that the placement would be to home. This is in contrast to Patient C whose resource structure is low and whose placement would be to a SNF. Both patients B and C, however, would have a longer than average length of stay. Patient D represents the case of the individual for whom the hospital has to absorb cost of patient care. In this case the patient would experience a shorter than average length of stay.

The purpose of these examples is to show how a person can be located within the hospital discharge and placement decision cube. Implied in these examples is that there is a space within the model that represents the average length of stay. Figure 4 explicitly describes this area of average length of stay (ALOS). The model posits that a patient not located in this area will experience something other than average length of stay, either shorter or longer. Patients located to the right of this area will experience longer than average lengths of stay; patients immediately above and below this area will have shorter than average lengths of stay. The model behaves this way since treatment purpose dominates length of stay and resource structure and cost to hospital will only shorten an already short length of stay.

Just as there is a space encompassing the average length of stay, there is a space specific to SNF placements. Figure 5 illustrates this area. SNF placements are associated with longer than average lengths of stay (therefore it is on the right half) and low resource structure. This area extends from low to high cost to the hospital since the placement

Figure 4

AREA OF AVERAGE LENGTH OF STAY WITHIN HOSPITAL DISCHARGE AND DECISION MODEL

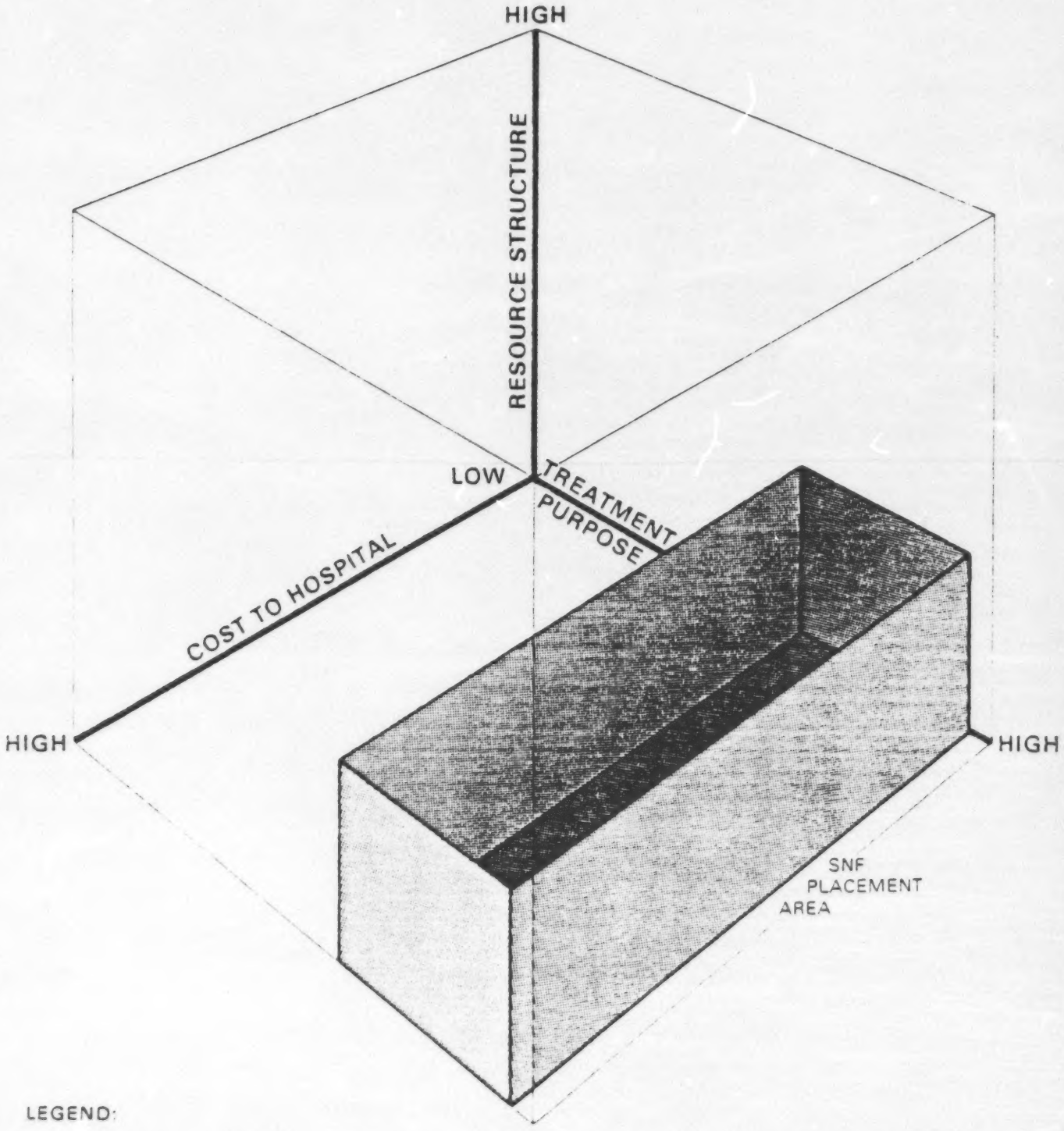


LEGEND:

Shaded interior cube represents the area of average length of stay. To the right represents longer than average length of stay. Above and below the shaded interior cube represents shorter than average length of stay.

Figure 5

SNF PLACEMENT AREA WITHIN HOSPITAL DISCHARGE AND PLACEMENT DECISION MODEL



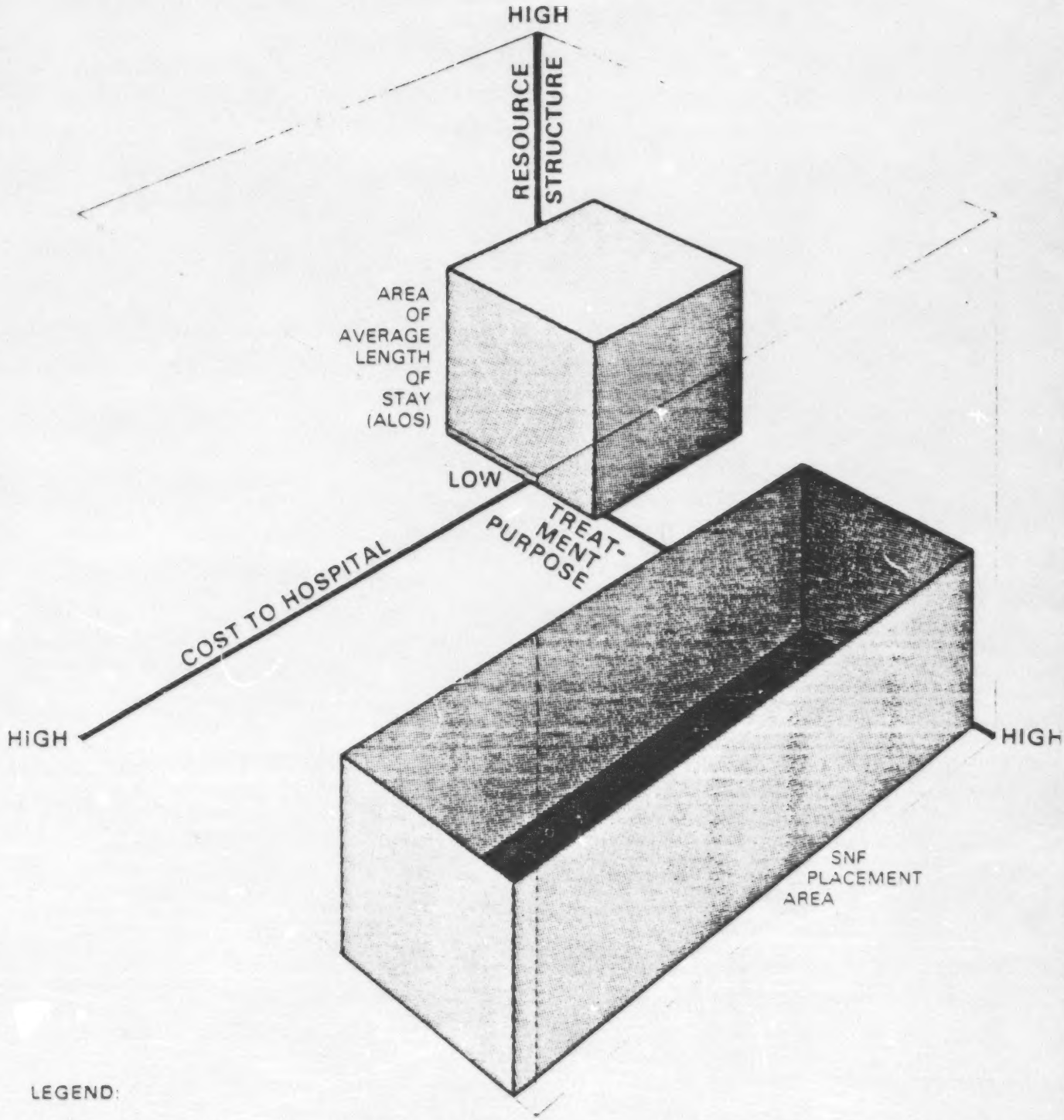
LEGEND:

SNF placement area is in lower right since SNF patients experience longer than average lengths of hospital stay due to medium to high treatment purposes but have low resource structure and therefore become SNF placements irrespective of cost to hospital.

could occur no matter where the person was located on this axis. The dominant factor for SNF placement is resource structure. Figure 6 represents the complete model.

Figure 6

HOSPITAL DISCHARGE AND PLACEMENT DECISION MODEL



LEGEND:

Model composed of three factors — Treatment Purpose, Resource Structure, and Cost to Hospital — which are continua ranging from low to high. Treatment purpose dominates lengths of stay decisions with ALOS area in low to medium range. High resource structure and/or high cost to hospital will shorten an average stay. Resource structure dominates placement decisions and low resources predict skilled nursing facility placement.

SUMMARY

Factors that dominate the discharge and placement decision are: treatment purpose, cost to the hospital, and resource structure. Each of these form axes or continua which run from high to low. Treaters, timekeepers, and supporters are social actors that personify the three axes or continua of the discharge and placement cube.

At hospital admission, the collective statuses of an individual patient will place him/her at some point along the continuum of each axis. Decisions of treaters, timekeepers, and supporters also move patients along the axes that they affect according to their own goals (treating, timkeeping, or supporting). Physicians and patients are the only actors whose role significantly affects all three axes.

The preceding discussion of discharge decision making describes the way the process works now. The vast majority of decisions are not negotiated nor need to be but are potentially negotiable. For those decisions that are negotiable, the strategy of hospital staff is to feed in information to physicians that will influence a favorable decision that will abet their goals vis-a-vis the patient and their professional orientations.

According to the three factors and the behavior of the actors, discharges will occur sooner or later than average and patients placed in a SNF or returned home. The Hospital Discharge and Placement Decision Model illustrates how these factors interact to predict ALOS and SNF placements. This model will explain and predict whether the placement will be to home or to a SNF.

Implications for Community Based Long-Term Care Agencies

A new actor on the scene in the world of the hospital is the community based long term care agency (CBLTCA). How is it to participate in, indeed influence the discharge and placement decision making process?

CBLTCA can influence treatment purpose by providing information to physicians about social contexts of patients. For example, strong doses of antihistamines for an aged woman's debilitating allergy were made unnecessary after case managers learned that she kept chickens, informed the physician, and helped her remove the offending birds.

CBLTCA can reduce hospital costs by protecting against social admissions, facilitating minimum lengths of stay, and providing the kind of after care that reduces readmissions. We observed in our case, that the agency is routinely called in by hospital social workers and discharge planners to contend with the most difficult discharge and placement problems. Given its relative funding flexibility, we act as the common sensical actor in these cases when existent Medicaid or social services' regulations create bureaucratic obstacles to appropriate placements and after care.

CBLTCA can act, finally, in a very real sense, like a caring family and thus become the organizer of a helping support structure. For example, case managers were instrumental in keeping both an aged mother and daughter out of the hospital when the daughter became ill and could not care for her extremely frail mother. Both women were disabled, but

had worked out a kind of self care reciprocity. They also did not want to be separated. Arrangements were made to care for the mother while the daughter recovered and a normal routine returned in about one week.

Suggestions

As the description of the discharge and placement decision making process indicates, physicians are key actors and suggestions to improve the efficacy of a community based service agency's intervention must be aimed primarily at them. Given our description and current reimbursement policies which have an institutional bias, this means changing decision premises which lead to a conclusion that SNF placements are the only option and that community based service agencies can save physicians time as well as provide better patient care. Educational campaigns, preferrably lead by physicians "friendly" to the concept, should be directed toward showing physicians, through case histories, that SNF placements do not have to be automatic for elderly patients. These case histories should emphasize how the agencies can save physicians' time by letting case management teams of social workers and nurses absorb time consuming telephone calls from families and friends that may also be emotionally draining. Information gathered by the case managers, particularly the nurses, could also complement the physicians' own records. CBLTCA can save hospitals money by facilitating a timely discharge (fewer administrative and decertified days); assist social services by managing a proportion of the caseload; and increase physician time by caring for the troubled and troublesome patient.

These efforts should be repeated on a cyclical basis in order to impress on physicians that the concept is credible and the agency's presence becomes part of the physician's reality.

Physician education, a long run strategy facing considerable historical, structural and interactional barriers to its success, is a sine qua non to constructing a system of long term care for the elderly. However, while waiting for long run effects, short term, operationally oriented changes can be made toward identifying clients and potential clients. Underlying these suggestions, is the notion that individuals, when making routine decisions, will only take into account one or two cues to arrive a a decision [25] and not comprehensively review and assess all stimuli. [26] Therefore, these suggestions, Figure 7, take the form of a multi-level onslaught of cues, each cue tailored to the different actors involved, that is, generating the knowledge that this elder patient belongs to a caring community program with ways and means to provide support. At the local level, the key is a case finder, paid by the community agency, who visits hospitals on a regular basis and who has authority to review admission records and place a notation on the patient's chart, perhaps a sticker similar to the allergy stickers commonly used in hsopitals, to alert the physician that the elderly patient is connected to a community agency. Similarly, nursing staff should also be notified. Face-to-face contact is chosen as the cue for social workers and discharge planners in order to personify the relationship. For the Medi-Cal reviewers and Utilization

Figure 7

SUGGESTIONS TO FACILITATE IDENTIFICATION OF HOSPITALIZED CLIENTS

	ACTOR	CUE	MEANS
1	Physician	Notation in/on medical records	Case finder (CF) from community agency with authority to make notes in/on chart
2.	Nurse	Notation in/on chart and logo in room	CF placing logo decal on chart and logo poster in room
3.	Social Worker	Face-to-face contact	CF visiting social service and attend patient management rounds
4	Discharge	Face-to-face contact	Same means for discharge planners
5.	Medi-Cal and Utilization Reviewers	Aid Code	Change Medi-Cal numbers

Review staff, the aid code within the 14 digit Medi-Cal number could be changed to "99" to signal that this patient is special. These suggestions may mean changes in law, particularly to allow an "outsider" access to the patient's chart, but without them community agencies may remain peripheral to these billion dollar decisions.

Critique

Problems related to the above suggestions, and inherent in any attempt to link an ouside community agency and hospital, may be identified in terms of the actors involved.

Regarding physicians, we have been informed (mostly by senior teaching faculty physicians) that physicians do not and will not read any but their own notes in a patient's chart. Additionally, we were told that a logo sticker on the front of a chart or posted in a patient's room would stimulate very little curiosity on the part of the physician to find out what it meant. One candid teaching physician explained that governmental regulatory attempts and staff persons that strive to involve themselves in decision making are often viewed by physicians merely as "more noise in the system". That is, more background static in the physician's customary procedure of making discharge and placement decisions. CBLTCA workers assisting a hospitalized client with such a physician in the current system will likely be the "...last of the last to know about an admission or discharge - right after the hospital social workers."

Even if significant organizational cooperation is achieved between agencies and individual hospitals, there remains the issue of physician ideology. A proportion of physicians have gone on record as being ideologically opposed to publically funded social service programs in general and projects involving health care in particular. Even approximate estimates as to the relative size of the percentage of physicians who have conservative ideologies have yet to be made.

Regarding nurses, we have learned of particular difficulties involving attitude, turf and turnover. First, generally speaking, nurses have not expressed strong feelings one way or the other about length of stay. With few exceptions they do not care, and the question does not arise. Nurses point out that their attention is necessarily focused upon admissions, not discharges, as this is when the work load is heaviest. One nurse admitted that she preferred to work Fridays in Family Practice Service because patients are routinely discharged for the weekend and there are few admissions.

Second, questions of turf and patient/client responsibility for hospital and agency nurses must be negotiated on almost a case by case basis - by hospital and community. The same situation of turf negotiation exists for all members of hospital and agency professional staff including social workers, reviewers and discharge planners. (At this early stage it appears that agency nurses may have the best chances of forming relations with hospital staff.)

Finally, a recent phenomena of nurse shortages, high turnover rates, and a growing popularity of work through the registry have contributed to personnel turnovers requiring increasing if not constant re-negotiation of working relationships between hospital nurses and MSSP professional staff.

Regarding hospital social workers, we noted that in several instances the pressures of cognitive dissonance has forced hospital social workers to buy into the medical model, sometimes creating ethical dilemmas.[27] Although MSSP does not suffer the consequences of a denied day, their responsibility does not end at the hospital curb either. Hospital curbs as lines of demarcation create vexing problems for hospital and MSSP social service workers alike. When a patient is decertified, whose problem is it? While MSSP may be scrambling around seeking a solution, the patient may be discharged to the curb.

Discharge planners as a group tend to be at a baccalaureate level or older female nurses operating with the scarcest of resources in a relatively low status position. Discharge planners argue that by definition and administration directive their responsibility stops at the hospital door. At the same time they must make good placements - recalling that some discharge planners also wear the hat of utilization reviewers thereby creating ethical dilemmas similar to the social worker.[27,28] Their hospital basement social status is probably in part responsible for an observed professional jealousy which perceives that MSSP is doing

a better job at after care with more money, time, and resources. It is understandable therefore when some MSSP staff report that discharge planners, at least initially, were not eager to cooperate. Cases of a hospital patient/MSSP client being transferred to another hospital and then to a SNF wihtout informing the MSSP staff is also understandable given discharge planners workload and time pressures and are not unique to this Project. [29]

Summary

Whose patient/client is he/she anyway? The problem of turf is a common thread running through this self-critique of suggested changes. Compounding territorial issues are the dynamics of the discharge and placement decision process which flow around the dimensions of time and timing, the organizing theme that forms our analytic framework of the interaction of factors and actors. Common sensical suggestions are rendered problematic in view of these interactional and structural complexities. Time to resolve organizational and professional boundry questions will be needed as well as time to work through procedural and process issues. A goal of establishing a continuum of care for the elderly is certainly noble but without resolving some prosaic problems the "continuum" may become a bedlam of unintelligible unproductive activities and the patient/client a victim.

Footnotes

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